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Methods of Combining Biomedicine with Traditional Medicine; The Chinese Example

By

Zuzana Marie Forgac ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of **Master of Arts.**

DEPARTMENT OF **ANTHROPOLOGY**

EDMONTON, ALBERTA

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UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled METHODS OF COMBINING BIOMEDICINE WITH TRADITIONAL MEDICINE; THE CHINESE EXAMPLE by ZUZANA MARIE FORGAC in partial fulfillment of the requirements for the degree of MASTER OF ARTS.

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Abstract

Due to increased discussion on incorporating traditional medical systems with biomedical systems to provide culturally appropriate care, a closer look at the actual methods of combination is undertaken. In Chapter One, a medical system is defined as including five elements: etiology, pathology, diagnosis, therapy and materia medica. The first two elements comprise theoretical concepts, while the three latter elements comprise the practice of a medical system. An examination of four policy approaches to traditional medicine and the World Health Organization's (WHO's) reasons for endorsing integration of traditional medicine with biomedicine is then undertaken. In the beginning of Chapter Two, a history of traditional Chinese medicine is provided. Results of a field study from a "combination" hospital in Beijing are then reported. The two medical systems in China rarely combine theoretical concepts. Integration in China focuses mostly on a combination of diagnosis, therapy and materia medica. In Chapter Three, the author argues that this is not true integration, and describes socio-political and theoretical hurdles that make integration impossible and undesirable. Finally an "active collaboration" approach to combining medical systems is endorsed as a better way to provide culturally appropriate care.

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This work represents an exploration of my own ideas. I take full responsibility for errors and omissions. My hope is that, in some small way, it will contribute to the preservation of a variety of medical systems in the world.

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Chapter One

Introduction to the Problem

What are the issues in integrating traditional medicine with biomedicine? For the past twenty years, the World Health Organization and other independent researchers (e.g., Neumann & Lauro) have stressed a need to integrate traditional medicine into mainstream biomedical health care systems.

In this thesis, official policy approaches and the feasibility of applying an integrated approach to health will be examined. In this first chapter, background issues, definitions and methods of incorporating biomedicine and traditional medicine are examined. The second chapter documents field research from a hospital in China, to illustrate examples of combined medical systems in practice. The last chapter critically examines social, political and theoretical hurdles to integration, and the underlying problem in contemporary integration policy.

This type of research is important precisely because there is little critical analysis available on the integration of biomedicine and traditional medicine. The World Health Organization advocates that governments attempt some form of integration between biomedicine and traditional medicine. However, the policy approaches toward integration are not well documented. Furthermore, the effect of integration policy on the medical systems involved, is not well researched. In order to develop effective policy several questions need to be addressed. What aspects of the medical systems are being combined? Are practitioners of both systems treated equally? Are the theory and practice of different medical systems combined? Does

one system dominate the other? Through examples from literature and field research in Beijing, I will show that when traditional medicine and biomedicine are integrated, traditional medicine is incorporated in a limited and strictly controlled fashion that subsumes it under the biomedical model. Adelman calls this process "institutionalization of traditional medicine" and argues that if special care is not taken, the institutionalization of traditional medical practices will negate the value of traditional beliefs and incorporate only selective practices (1992).

In this chapter, I will illustrate that there is a void in contemporary discussions of integration policy (biomedicine and traditional medicine). I will demonstrate the necessity for further examination of integration policy and related issues. This is approached in three steps. First, reasons for the advocacy of incorporating traditional medical systems with biomedical ones are looked at. Second, four policy approaches concerning traditional medicine are examined. And finally, integration policy and some underlying questions will be examined.

Definition of Terms

Biomedicine is the orthodox system in Western industrialized countries and includes treatments, for example, drugs such as hormones, antibiotics and pain killers; surgical techniques; physiotherapy and psychotherapy. Biomedicine is synonymous with Western medicine, modern medicine, allopathic, orthodox and cosmopolitan medicine.

Traditional medicine can take a variety of forms. It may be a well-organized, historical system such as Ayurveda in India or traditional Chinese medicine (TCM) in China. It may also be a system lacking a written history, which is described, in present form, by anthropologists or others such as missionary doctors (Foster in WHO 1983). Thus traditional medicine can refer to anything from using locally made herbal remedies to shamanistic healing. The World Health Organization, using a definition arrived at by a group of experts from the African Region, states that

> (Traditional medicine) is the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing... Traditional medicine might also be considered as a solid amalgamation of dynamic medical know-how and ancestral experience. (WHO Technical Report Series 1978:8)

Common synonyms for traditional medicine include; indigenous, unorthodox, ethno or fringe. In some literature, unofficial or alternative medicine is used synonymously with traditional medicine. In this thesis alternative medicine is considered to be medical practices that are generally not part of the dominant medical system and whose origins are not associated with a particular ethnic group. For example, homeopathy in Canada is an alternative medical practice because it is not officially accepted by the biomedical system and did not originate in any one particular ethnic group (Weil 1988).

Historically, traditional Chinese medicine used many modalities. As it is not possible to examine them all, within the confines of this thesis, discussions of

traditional Chinese medicine are limited to what the Chinese government officially recognizes as TCM. This includes herbal medicine, acupuncture, moxibustion, massage therapy (several forms), Qigong and diet therapy (SATCM 1990).

Generally, there are two types of groups practicing traditional medicine within a community: folk healers and traditional practitioners. Although folk healers and traditional practitioners may function together in one community, their roles and expertise are quite different. Folk medicine consists of practices based on common knowledge available to the average person. A folk healer does not need special training (Kleinman 1978). On the other hand, the traditional practitioner is a highly trained specialist and is,

> a person who is recognized by the community as competent to provide care by the use of methods that are based on the social, cultural and religious background, as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability. (Eisenbruch 1989:575)

In this thesis, references to traditional healers reflect the above definition, and do not include folk healers.

The distinction between "health care system" and "medical system" is often not clear in the literature. Kleinman believes that health care systems include three main sectors: folk, popular and professional. Each arena encompasses health beliefs and behaviours and illness beliefs and behaviours. For example "the popular arena comprises principally the family context of sickness and care, but also includes social network and community activities" (1978:86). Thus, the health care system includes beliefs, choices and decisions, roles, relationships, interactions and

institutions in each arena. Health care in this context would also include all preventive care. Dunn defines a medical system succinctly as "the pattern of social institutions and cultural traditions that evolves from deliberate behavior to enhance health" (1976:135). Kleinman and Dunn both include social and cultural interactions in their definitions of a health care system. They also use "health care system" and "medical system" synonymously. However, I believe that a distinction between "health care system" and "medical system" is useful to this thesis. In this discussion, the term "health care system" includes all the above arenas and preventive care. The term "medical system" is used to define only that aspect of a health care system that is activated when disease or illness is identified in a patient, and includes the social interactions, beliefs, relationships and roles thereafter. My discussion is limited to medical systems because research was primarily conducted in a hospital setting, where preventive health care analysis would have been inappropriate.

In summary, the term "medical system" in this thesis refers to Kleinman's model of the professional arena in a health care system (1978:87). This arena, according to Kleinman, consists of professional scientific ("Western" or "cosmopolitan") medicine and professionalized indigenous healing traditions, such as traditional Chinese, Ayurvedic, or Yunani. At the same time the professional arena also includes any beliefs, choices and decisions, roles, relationships, interaction settings and institutions. Although I accept Kleinman's model of the professional arena, I do not wish to limit my discussion of a medical system to a

traditional practitioner in the professionalized healing traditions described above. Rather, I include in my definition of professional medical system, a traditional practitioner who has gained knowledge, either through formal training or apprenticeship, and is recognized by the community as a specialist.

Furthermore, a medical system is based on five important factors that make up the underlying belief system and practices used by it. These five factors are: theories concerning the causes of disease (etiology), theories concerning the disease process (pathology), identification of the illness, classifying its appearance by history, circumstance or symptoms (diagnosis), application of actions understood and intended to modify the causes or effects of the illness (therapy), and the resources available for treatment such as drugs, devices or persons (materia medica). Outcome and explanation of treatment results are included in the pathology (Kunstadter 1974 & Vuori 1982).

Hence, a medical system consists of these five factors in intricate interplay. The underlying theoretical constructs (etiology and pathology) direct the *focus*, if you will, of the activities (diagnosis and therapy) while utilizing available tools (materia medica). All of these factors are intertwined, while three, diagnosis, therapy and materia medica, are manifestations of concepts of etiology and pathology.

Theoretical Approach Employed

In this thesis, methods of combining medical systems are examined using cross-cultural comparison. I advocate for a model of medical pluralism. In this model, cultural beliefs and perceptions play an important role in defining what are appropriate responses to health questions. In a medical pluralistic system, different methods of treating medical issues exist. I also argue for the acceptance of Arthur Kleinman's statement that medical systems are symbolic systems that rely on meanings, values and behavioural norms (1978). From this statement it follows that medical systems are embedded in the culture in which they exist and are therefore not culture-free.

Medical Pluralism: What is it?

Pluralism is defined as a social condition in which a number of disparate ethnic, religious and racial groups exist within one common community (Webster's 1989:1209). As applied to the study of medical systems, pluralism occurs at any time when several medical systems work together within a community. Medical pluralism allows for diversity and a variety of approaches to treat illness and disease by providing members of a community choice in exploring whichever treatment method they see fit, or whichever method is congruent with their concept of healing. Every society, past and present, has some form of traditional medicine, although other than biomedicine, few are officially recognized.

Alternative healing practices, then, are those medical systems that exist outside the officially recognized and supported system.

Leslie believes that many governments have sought to control or severely restrict "irregular practices" outside of the dominant medical system so that only one medical system exists within a country. He states,

> This goal is a powerful force in modern history because it expresses the dream of a future good society in which modern science will be used benevolently and rationally to relieve human suffering and distress. ... No real medical systems realize this dream. (1980:191)

In spite of attempts to control such practices in countries where only the biomedical system is officially recognized, a pluralistic system still exists. For example, in Canada the biomedical model is the dominant paradigm, yet outside the official medical system traditional aboriginal healers, homeopaths and traditional Chinese practitioners can be accessed with relative ease. The People's Republic of China is also a model of medical pluralism because biomedicine, traditional Chinese medicine, minority medical traditions (such as Tibetan or Mongolian medicine) and shamanistic practices function in the same arena.

Reasons for the Incorporation of Biomedical and Traditional Medical Systems

Over the past twenty years, world-wide attention has focused on the unofficial medical systems. Traditional medicine has come to be recognized as a valuable resource to meet the varying medical needs of a population. There is a growing amount of literature extolling the need to incorporate traditional healing practices within biomedicine in the official sector to provide a truly comprehensive medical system. For instance, Neumann and Lauro discuss the possible strategies

for linking biomedicine and traditional medicine. They argue that linking the systems would provide culturally appropriate care, lower costs and greater access to medical care for isolated people (1982:1819). The World Health Organization (WHO) has been advocating the incorporation of traditional medicine and biomedicine for over twenty years, initially prompted by a joint UNICEF/ WHO study on alternative approaches to meeting basic health needs in developing countries. In 1977, the WHO's Thirtieth World Assembly passed a resolution (WHA30.49), which advocated the promotion and development of training and research in traditional medicine in developing countries. Since then, the WHO has been active in setting up regional groups, special programs and guidelines to support the resolution. By opening the Regional Office for the Americas and the European Region, the WHO expanded the scope of the original resolution. They now include study on, and incorporation of, traditional medicine in developed countries as well. However highest priority continues to be given to developing countries (Akerele 1984, Vuori 1982 & WHO Technical Report Series 1978).

The World Health Organization promotes the incorporation of traditional and biomedical systems for the following reasons: a) traditional medical systems are existent and functioning, b) traditional systems provide culturally appropriate care and c) use of traditional practitioners can expand the resources to achieve "Health for All by the Year 2000" (1983).

a) It has been shown that traditional medical practices persist in the contemporary world (e.g., Neumann 1971; McClain 1977; Lambo 1978). In

developed countries, traditional medicine is often quite prevalent among ethnic communities and indigenous peoples. Vuori found that reliance on traditional medical systems persists in every country regardless of the degree of modernization,

> The extensive use of, and reliance on, traditional medicine is not only the result of a lack of modern services. Such services are certainly scarce in many rural parts of the developing world, but even where they do exist they may be poorly utilized, the local population using - and even showing a preference for - the services of traditional healers... Even in countries deeply permeated by the scientific-technological approach to medicine, the population still cherishes many traditional healing practices and relies on traditional healers to a greater extent than is usually realized or admitted. (1982:129)

Studies show that people seeking medical care generally feel no distinction between treatments that are officially supported and those on the fringe of the system. In a review article, Waldram found that traditional peoples,

> rarely see any difficulties in such a utilization pattern, even where biomedicine and traditional medical systems are inherently hostile to each other (as in North America)... More convincing research, based heavily on consumers themselves, has demonstrated that they frequently do not view these medical systems as separate, but rather see them as sectors or components of a single system . (1990:327)

Waldram, reporting on research with several native groups in Saskatoon, concludes that "those people retaining elements of their traditional medical system frequently utilize it in conjunction with biomedicine" (1990:342). Use of two different medical systems did not seem problematic for the population in this study.

Similarly, Leslie analyzed surveys that describe beliefs and practices in developing countries. He concluded that the concern for therapy is entirely practical and people see "nothing inconsistent in using modern and traditional

medications together, or in combining chemotherapy with rituals to alleviate sorcery" (1980:194). Rather than being confusing, it has been shown that people have patterns of resort that include one or all the above depending on the needs of the particular situation (Young 1983).

b) WHO stressed that primary health care (i.e., the first level of contact of individuals, the family and the community with the National health system) should be culturally acceptable and appropriate (1988). Culturally appropriate health care occurs when a patient is able to understand the illness experience in terms that are meaningful to him or her. Kleinman suggests that health care systems are similar to other cultural systems, like kinship and religious systems, in that they are symbolic systems that rely on meanings, values and behavioural norms. He states,

> The health care system articulates illness as a cultural idiom, linking beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices and, evaluations of therapeutic outcomes. (1978:86)

He notes that the practitioners, patients and family members use systems of knowledge, called explanatory models (EMs), to explain any of five issues: etiology; onset of symptoms; pathophysiology; course of sickness; and treatment. He then suggests that those health care relationships, where there are different EMs, can be studied and compared. He concludes that when EMs conflict, these conflicts can impede health care. Therefore, cultural healing, according to Kleinman and culturally appropriate health care, according to the WHO, can only occur when a person receives valuation of the expression of illness in familiar cultural terms.

Anderson also believes that illness must be understood in its entire cultural context for appropriate healing to occur,

> Although cultural categories confer specific meanings on illness, the experiencing of illness is embedded in a complex cultural, family and social nexus. Illness experiences must be understood within the total context of the patient's life, including the social organization of the dominant health care system and the ideological structures underlying health care practices (1986:1277).

It follows that an individual's cultural background affects concepts of health, which in turn affect any interaction with health care practitioners. Thus, compliance with prescribed treatments and even the outcome of the illness itself can be affected (Eisenbruch 1989).

What happens when the patient and the practitioner are members of different cultural groups? Examples in native health issues in Canada illustrate this scenario. In Canada, aboriginal people experience a shorter life span, higher infant mortality, more infectious diseases and higher risks from accidents than non-native Canadians (Mardiros 1987). Rachlis & Kushner add that "infectious-disease rates among native people compare with those found in the third world" (1989:183). Differences in disease rates can be connected with other factors such as socio-economic status. However, cultural factors also play a role. One of the difficulties observed in a medical exchange was due to cultural differences in communication. Cooke notes that,

> (Native people) tend to talk around a matter rather than directly about it, which drives (non-natives) crazy. The problem is the doctor can see out the door that he has fifteen patients waiting. A lot of times if a (native person) feels that the doctor is impatient he'll just walk out believing that no one cares to take the time. So the medicine must be no good. (1990:74)

The local Native conception of what is appropriate behaviour compared to what is expected in the dominant medical system, can make it a challenge to simply transfer information (Shah 1988).

Traditional doctors are able to provide culturally appropriate care because they tend to be from the community in which they serve (Bibeau 1985). Thus, they can meet biopsychosocial needs (physical, mental and social) by treating the whole person within an environment (Ataudo 1985). Ataudo believes that,

> the traditional doctors play important roles in the management of the patient, and contact between the patient and the traditional doctor is much closer than between the patient and the modern medical doctors. (1985:1347)

In contemporary terms this type of treatment is called holistic. Likewise, others argue that traditional practitioners take a holistic approach to health by treating the patient on several levels at the same time; individual, part of a social community and part of the environment (Morse, Young & Swartz 1991). For example, traditional medical treatment may consist of a ritual where the family of the ill member are present, adding a social or community element to illness. When a person is treated as a member of the community, the treatment can help solve stresses caused by conflicts and tensions in the community and promote better group communication (Lambo 1978).

In Canada, Jilek and Todd found that the best treatment for Coast Salish natives suffering from depression, anxiety, somatic complaints, behavioural and alcohol related problems, was an indigenous ceremony called the Spirit Dance. This traditional ceremony was more successful in the long-term rehabilitation of

complaints than the standard biomedical treatment. The indigenous method treated patients in culturally recognizable and appropriate ways and left their belief system intact. A further finding demonstrated that the health problems of Coast Salish people were not approached as individual problems; rather they were treated as part of the larger socio-cultural situation (1974).

c) Practical concerns that are pressing governments to consider alternative ways of addressing medical needs are resources: people and money. To achieve the WHO's goal of "Health for all by the Year 2000", all Member States of the World Health Organizaion are asked to employ all possible resources. These include various types of traditional practitioners and birth attendants and the methods of various kinds of indigenous practitioners (WHO 1983). Incorporating traditional practitioners into national medical programs could expand the capabilities of a medical system and allow it to service areas previously inaccessible or where biomedical personnel are not well accepted,

> By securing the cooperation of traditional practitioners, Member States are utilizing one of the most abundant and valuable health resources that they have to extend health coverage. Traditional practitioners are, as a rule, important and influential members of their communities, and they should be associated with any move to develop health services at the local level (Akerele 1987:177)

Finally, incorporating traditional medicine with biomedicine is advocated as a way to provide inexpensive primary health care to developing countries. For example, simple remedies for common ailments can be made from local pharmacopoeia. Akerele believes that once it is demonstrated that traditional plants can substitute for imported drugs, local production can contribute to economic

self-reliance (1987). Local rituals for psychosocial conditions can be encouraged instead of hospitalizing individuals away from their communities (Jilek & Todd 1974). Undoubtedly these cost-cutting measures using indigenous or local ethnic medical knowledge could also benefit developed countries. Effective and culturally appropriate remedies, by local healers, for many common illnesses could be dealt with at community centres, thus freeing up expensive hospital beds and doctors' offices.

To sum up, medical pluralism exists unofficially around the globe. For over twenty years, the WHO has been actively encouraging developing countries to give official recognition to this resource to promote culturally appropriate medical care and expand health resources. For similar reasons, industrialized countries have been studying their indigenous peoples and ethnic populations. The following section looks at four approaches for governing traditional medicine.

Four Approaches to Policy Concerning Traditional Medicine

In the 1983 WHO publication, Traditional Medicine and Health Care Coverage, several authors outline four main types of organizational relationships between official and traditional health care services. To address methods of combining medicines in this thesis, there must be a basis from which to analyze the type of official medical system that exists. Therefore, I will use the WHO's categories when discussing policy in the next two chapters.

Writing in the WHO book, Stepan defines four types of organizational relationships: exclusive, tolerant, inclusive and integrated. In the introduction, Bannerman, Burton and Wen-Chieh label the same four categories: monopolistic, tolerant, parallel and integrated. I will use the terms coined by Bannerman et al. Note, however, that the definition and usage of terms are the same throughout the WHO book.

The first policy approach is called **monopolistic.** The government gives only biomedical practitioners the right to practice medicine. Other medical systems may exist, but they are forced to work underground. The second type of policy is termed **tolerant.** While authorities do not officially recognize traditional medicine, in tolerant systems, biomedical exclusivity is limited to specific medical and public health activities. Traditional and unofficial practitioners are able to work and be paid for services in all other fields as long as they do not claim to be registered medical doctors. The third policy type is known as **parallel**, where biomedical practitioners and other approaches to medical care are officially recognized and provide services to patients through separate systems that are considered equal. Finally, the fourth policy approach is known as **integrated**. Here modern medicine and traditional medicine are merged in medical education and jointly practiced, thus forming a unique health service (Bannerman, Burton & Wen-Chieh in WHO 1983).

The fourth policy type, integrated, has received the most attention in literature. This policy initiative is most strongly advocated by the WHO. From an introduction by Mahler,

> The Declaration of Alma-Ata, describing primary health care referred to the need for a variety of health workers, including traditional practitioners as needed, who are suitably trained socially and technically to work as a health team and to respond to the expressed need of the community. (1983:7)

Using the definitions of policy types described above, I surveyed some of the literature on countries that are attempting collaboration with traditional doctors. Additionally, I provide information from a sampling of countries related to their official policy towards un-official medicine. Official recognition can be determined by examining whether practices are covered by a national health insurance plan, or if no such plan exists, whether the government financially supports institutions or training centres of traditional medicine.

The medical system of the United States in the mid-eighteen hundreds provides a good example of a monopolistic system. At this time, the American Medical Association (AMA) was actively prosecuting allopathic doctors who consulted with any alternative practitioner. The AMA also published literature against alternative systems and gained control of hospitals and boards of health (Weil 1988).

The Canadian medical system today can be categorized as a tolerant system. Some provincial health policy does allow for certain alternative practices, such as homeopathy, but there is no official recognition of these or any indigenous practices as medicine (e.g., Vayda & Deber 1984; Morse et al., 1991). Young calls

this type of system a tolerant orthodoxy. Moreover, he suggests that the Canadian system has taken this model one step beyond tolerance and adopted a policy of multicultural health. He notes,

> In an attempt to provide culturally-appropriate health care, tolerant orthodox practitioners make an effort to understand the beliefs and behaviours of minority patients, and may even supplement their normal procedures with techniques borrowed from alternative therapies. (1994)

Supporters of multicultural health endorse training orthodox (biomedical) practitioners to be culturally sensitive. This is achieved by categorizing ethnic groups. Generalizations made about a group are then used to try to predict an individual's response to interaction in a biomedical setting (e.g., Waxler-Morrison, Anderson & Richardson). Masi also advocates sensitizing biomedical health care providers to different cultural perspectives on health and illness. He claims that there is no one system that will work for all in a multicultural society and that,

> Culturally sensitive health care is not a matter of simple formulas or prescriptions for care that provide *the* answer; rather, it requires understanding of the principles on which health care is based and the manner in which culture may influence those principles. (emphasis in original, 1988:2173)

Note, however, that in this model biomedical personnel maintain control over medical practices. Generally, cultural differences are studied, not with the intention to further knowledge on health and illness processes as a whole; rather, they are researched to be utilized as tools to aid in biomedical treatment.

A recent paper on medicine in Norway reported on the progress of discussion between biomedical practitioners and traditional healers. The discussion

group was created to promote better communication and understanding between these two medical systems in the hope that they would be able to integrate the best aspects of both systems in the future. The group appears to be working. There is indeed better communication, understanding and even some informal referrals between the practitioners of these two systems. However the organizational structure in Norway is at present a tolerant one (Christie 1991). Vuori concludes that in general, official and professional attitudes towards traditional practitioners in Europe are cautious (1982).

India has a long history of the highly organized traditional medical system, Ayurveda. It is used by 80 per cent of the rural population and there are separate medical schools and colleges for the training of Ayurvedic practitioners. Vuori noted that in 1982, some training institutes offered integrated courses. Yet, of the 500,000 traditional practitioners, most received their training through apprenticeship with older traditional doctors. Ayurvedic medicine is also practiced in Bangladesh, Nepal, Pakistan and Sri Lanka. Kurup, in a WHO report, states that these southeast Asian countries "permit parallel functioning of their traditional, indigenous systems with the modern health care system" (1983:58). He also concludes that while integration is the ultimate goal, more medical schools are needed to teach Ayurveda to realize that goal. Furthermore, existing hospitals all function under either the biomedical or Ayurvedic model. There are no organized combination hospitals. In short, there is no indication that the government is

approaching integration through official policy. The systems remain quite separate and follow a parallel system approach.

In Nigeria, nurses were surveyed on their opinions concerning traditional medicine (Odebiyi 1990). The study concluded that nurses were in favour of a parallel system of organization. They also said they would like to collaborate with traditional healers following the establishment of separate medical schools and hospitals. Of particular interest was the statement that although collaboration was anticipated, the nurses wanted to ensure that they were able to exert control. So, collaboration was desirable to the biomedically trained nurses only if they were in power. The Nigerian medical system, then, can be classified as tolerant as the healers are not officially recognized.

Another African country, Zaire has begun to consider the possibility of collaborating with traditional healers. Yoder examined the stages that are necessary to create a mutual referral system between the two different practitioners, perhaps ultimately leading to a parallel systems approach (1982). From the study, however, it appears that Zaire currently has a monopolistic system of organization.

Ethiopia and Tswana both have tolerant systems of organization but are attempting an integrated health policy approach with their traditional healers (Bishaw 1991 & Haram 1991).

To sum up, many countries are only beginning to consider integration or creation of a parallel system of organization. Furthermore, biomedical practitioners

have mixed feelings about the integration process. Most systems today consist of monopolistic or tolerant style health care policy.

Questions Underlying Integrating Medical Systems

If the definition of medical system, composed of the five factors (etiology, pathology, diagnosis, therapy and materia medica), is applied to the study of integration, it becomes a useful tool of analysis. Integration is defined as the system that fully merges medical education and jointly practices both biomedicine and traditional medicine. However, precisely what aspects of a traditional medical system should be integrated to provide culturally appropriate care? Are both medical systems examined in their entire cultural context?

Vuori's report for the WHO, states that the intrinsic value of traditional medicine can be divided into two categories: cultural value and medical value (1982). He suggests that the cultural value should be respected solely as part of the cultural heritage and it is sufficient to accumulate this wisdom in order to make it available in publications and museums. Vuori further suggests that the medical value of traditional medicine does interest the WHO, but it should be examined using modern scientific methods.

There is one important assumption in the above statement that needs to be examined. Is there a clear distinction between cultural value and medical value? Contrary to Vuori, I think that the distinction between the useful cultural aspects of a medical system and the so-called medical aspects of a system are very difficult

to separate. Kleinman argued that "because they are part of a cultural system, health, illness and health care need to be understood in *relation* to each other" (emphasis in original, 1978:86). That is, all of these relationships interact. If integration is pursued to provide culturally appropriate care, then it is pursued in spite of the lack of distinction between cultural value and medical value. For the most part the two are inseparable. For instance, if all of the unknown aspects (e.g., pscyho-social-spiritual aspects) that are thought to contribute to "cultural healing" are placed at one end of a continuum, and if all bio-chemical aspects of healing that contribute to the "medical value" of healing are placed at the other end, where is the middle of the continuum? Where exactly do the two come together? Kunstadter says that there are some illnesses that have a biological component (1974). These illnesses are universal and not subject to cultural re-interpretation. Yet,

> we have good evidence of the interaction of culture and illness, and thus feel that illness is in some important senses culturally defined (e.g., in the patterned interpretation of symptoms by participants in any cultural system), and even culturally created (e.g., by behaviour patterns which have known associations with risks of illness, such as smoking in our culture, or hunting lions in Africa) (1974:683)

It follows that to study medical systems from other cultures, the entire system needs to be looked at in cultural context. Integration, by definition will not be complete unless all five factors of a medical system are considered.

Integration of Traditional Chinese Medicine -- Policy and Practice

The People's Republic of China has had extensive experience with combining traditional Chinese medicine and biomedicine. Today the Chinese government is encouraging a revival of TCM. Over the past fifty years, policy officials have alternated between pursuing parallel and integrated policy approaches (Lampton 1977). Traditional Chinese medical institutes and hospitals now function alongside biomedical ones. In recent integration initiatives, the Chinese government has set up research institutes and hospitals that purport to use a "combination" of the two medical systems. It is this setting that I chose to study.

China is a timely study project because of the length of experience in dealing with issues of medical pluralism. The People's Republic of China also has extensive experience in responding to WHO's "Health for All" mandate to utilize traditional medicine. They are further along in this process than most countries. Thus, China provides an ideal setting from which to observe the strengths and weaknesses of an integrated approach to medicine. In the following chapter, I use the Chinese example of "combination" policy in practice to illustrate where the system is not fully integrated.

Chapter Two

TCM History and Present Day Status

The present status of traditional Chinese medicine in relation to Western medicine is a result of a long, complex and changing political climate in China. It is necessary to briefly survey the roots and development of TCM and Western medicine in order to better understand the present situation. In the following history section I introduce historical material as background to an understanding of the interplay between TCM and biomedicine in a present day hospital setting. To provide this historical background, I rely upon the key scholars in the field.

Traditional Chinese Medicine -- History of Theory and Practice

> Classical Chinese medicine [or TCM] is based on Chinese cosmological ideologies, of which the primary ones are the balance between *yin* (representing the dark, moist, feminine) and *yang* (representing the bright, dry, masculine) forces of the Universe, the interplay among the five elements (metal, wood, water, fire and earth) and the close interdependence between the Macrocosm and Microcosm. [TCM is] based on naturalistic and rationalistic principles. It has an abstract theoretical framework, an elaborate system of diagnosis, and a detailed classification of diseases and medicaments. (Lee 1982:631)

Classical Chinese medicine, as it is practiced today, has a long history. According to Porkert, an oral medical tradition existed from at least the second millennium BC in China (1976). There is evidence that acupuncture existed in the old stone age, several thousand years ago. A particular kind of stone was used as a needle for specific points and edges of stones were used for bloodletting. During the Ching and Han dynasty, from 470 BC to 221 AD, a book for traditional Chinese

internal medicine appeared called "Inner Classic of the Yellow Sovereign." This book contains records on the use of massage to treat arthritis, stomach aches and muscular atrophy, as well as developments in the use of needles, moxas and drugs (Porkert 1976). Other Han dynasty documents that extend from the period of roughly 200 BC to 200 AD indicate an awareness of the problems of public welfare and hygiene. The collapse of the Han empire appears to have had no negative effects on the evolution of medicine. By the third century a number of fundamental medical texts appeared. One text, the "Systematic Classic on Acu-Moxi-Therapy" reproduced passages on sinarteriology, acupuncture and moxibustion from the original "Inner Classic of the Yellow Sovereign". It became quite famous because it was characterized by a simplicity and precision that translated well to practical applications. From the third to the tenth century a number of texts appeared discussing, among other things, an inventory of therapeutic techniques, prescriptions, descriptions of different diseases and topics such as acupuncture, obstetrics and dietetics. In the histories of the Sui (589 - 618) and T'ang (618 - 960) dynasties, repeated mention is made of an institution called "Great Medical Bureau under T'ang", which had teaching facilities and a garden for raising medicinal plants. It appears this bureau was later enlarged and included separate departments for compiling and editing medical texts, as well as a department for training about 300 students with annual examinations and grading of students and staff (Porkert 1976). Thus institutionalization and standardization of medical science was an ongoing endeavor throughout the T'ang Dynasty.

In 1026 Wang Wei-i completed life size bronze models of humans, showing acupuncture points, which are still in use today, and wrote a text on his observations of these points. Later, in the Sung era, an extensive encyclopedia of herbal pharmacopoeia was compiled. A revised edition was published in 1116. This was an amazing accomplishment according to Porkert,

> This compilation brought together all pharmacological data that had been transmitted in the traditional pharmacological and medical texts as well as Confucian, Taoist and Buddhist authors and in the histories. (1976:74)

During the Ming and Ch'ing Dynasties some great works appeared. One particularly famous book, the "Standard Inventory of Pharmacology", was written by Li Shih-Chen, who spent 26 years researching and compiling details on 1,892 medicinal drugs and over 10,000 prescriptions. It was completed in 1578 and played a very important role in the development of chemistry and pharmacology (Gao 1991c).

There is little information in the literature on traditional Chinese medical development from the 1600's to the 1800's. In the early 1800's, the influence of Western religious missionaries, Christian and Protestant, began to make itself felt.

The Introduction of Western Medicine

During the nineteenth century Western medicine was introduced through medical missionaries who established medical missions, medical schools, orphanages and mission outposts. According to Crozier,

> The medical missionary movement itself was, of course, closely tied to the exertion of Western military power which forced China to accept Western commerce, Western institutions, and eventually Western culture.... The fact is that Western medicine was an integral part of Western cultural aggression and ultimately of Chinese cultural revolution. (1968:36-37)

After the Opium War (1839-1842) medical missions grew into four newly created treaty ports. The number of Western medical missions reached a peak of 326 hospitals and 244 out-patient clinics by the turn of the century (Crozier 1968). Missions not only dispensed medical treatments but also spread modern medical knowledge among the Chinese. Western physicians frequently took on Chinese assistants and gave local Chinese-style physicians lessons in anatomy and Western medical techniques. Modern medical schools gradually emerged from this type of training: the first in 1866. By the 1890's they were quite numerous.

Chinese acceptance of Western medicine was aided by the fact that a few practices had obvious benefits. Nonetheless, a large part of the country was still under the care of traditional practitioners. China with its vast rural areas could not possibly be serviced with a few hundred mission hospitals. Many were in urban areas and thus it was easier for modern medicine to take a stronger hold in large urban centers where missions were more prevalent (Wu & Sonoda 1985). However, even in urban centers Chinese people did not give up their Chinese medical traditions. Much to the dismay of medical missionaries, patrons of missionary hospitals would often use traditional Chinese medicine simultaneously for medical problems (Crozier 1968).

Official partial acceptance of Western medicine was indicated in 1903, when the Chinese central government set up a Medical Profession Academy at the Imperial University. Here they taught both modern and traditional medicine. In 1908, the government created a law attempting to enforce the examination and registration of traditional and modern doctors. It was not binding, lacked clear guidelines and it later proved unworkable (Crozier 1968). From 1910 to 1911 a devastating epidemic known as the "Great Manchurian Plague" broke out in the Chinese countryside and claimed over 60,000 lives. One of the biggest contributions of Western medicine during this epidemic was not the provision of medicine, but the lessons based on the germ theory of disease. This led to improved sanitation and public hygiene which helped curtail the spread of the epidemic. These measures were introduced by a Cambridge educated Malayan-Chinese doctor. The success and effectiveness of these measures prompted the government to adopt biomedicine exclusively for the officially approved medical curriculum. In 1915,

> the government thus gave official recognition to modern-style doctors only, but without explicitly banning the traditional practitioners. In 1922 the legal situation was somewhat clarified by Ministry of Interior regulations, defining two types of doctors, the traditional physicians clearly assigned to a separate and lower category. (Crozier 1968:47)

The 1922 regulation was intended to provide standards of qualifications for the two types of doctors. As such, it was the first attempt to regulate practice of Chinese medicine at a national level. Traditional doctors feared that this policy was the first step in an initiative to restrict their practice. Those fears were realized in

1929. The Ministry of Health effectively ended the dual medical status created in 1922 with the 1929 "Provisional Regulations for Physicians", by referring only to biomedically-trained practitioners as "physicians". The next month the Ministry of Health held a conference with the intent to completely abolish traditional medicine, but opposition from the national organization of traditional doctors was strong. They were able to exert effective political pressure at the Kuomintang's Third Party Congress and eventually, in 1930, the "Provisional Regulations for Physicians" were restated to apply only to Western-style physicians, while acknowledging the existence of traditional practitioners (Crozier 1968). Ironically, it was the threat of hostile government legislation that led to the formation of professional organizations of traditional doctors. Thus the unification of a previously individualistic traditional practice was well underway. This may have helped TCM to survive to the present day.

Crozier describes the nineteen-thirties as a period in which a prolonged tug of war took place over government policy toward Chinese medicine, with no binding resolutions or policies arising. Meanwhile, the number of graduates from modern medical schools increased greatly. Although a majority of the modern doctors in China were Chinese, most of the medical establishments were foreign-run. In the thirties and forties, advocates of biomedicine were disappointed to find that the numbers of graduates trained in modern medicine were woefully inadequate to serve China's rural needs. Therefore, Crozier claims, the lofty ideals of widespread modern medicine and equal access to all, were not realized by the

Nationalist government. Consequently, in 1949 with the founding of the People's Republic, the national government inherited a "situation where old-style medicine still prevailed over most of the country" (Crozier 1968:55).

Major Policies and Initiatives toward TCM from 1949 to Present

The Chinese Medical Association on its first meeting after the liberation in June 1949 decided that the unscientific native medicine had to be reoriented in some regions of the country and duly abolished in others. Bibeau notes,

> that the Chinese Medical Association staffed by Western-trained urban doctors was ambivalent in its early attitude toward traditional Chinese medicine and that they considered it inferior. (1985:939)

Chairman Mao Tse-Tung at the time of the revolutionary war in 1944 was also very critical of traditional Chinese medicine. In spite of this, Mao advocated the use of traditional doctors, but solely for their utility in serving the large Chinese population. Traditional Chinese doctors, according to Mao, needed to be re-educated to new viewpoints and methods of modern science. It was assumed that given exposure to modern science, TCM would inevitably give way to modern methods (Crozier 1968). At the first National Health Conferences in 1950 and 1951, the utilization of Chinese medicine was recommended due to the fact that it was readily available rather than because of any inherent value it had (Bibeau 1985).

In 1949, after founding the People's Republic of China, the government found that almost half of the people preferred using TCM. A few years later, Chairman Mao changed his mind based on the realization that Chinese medicine

was a large force with close connections to Chinese culture. Government doctrine changed, stressing the need for the two medicines to unite. Traditional doctors were to use scientific procedures and Western trained doctors were encouraged to study some traditional medicine, but were not bound to do so.

The political climate changed again in the latter part of 1954, when a campaign to eliminate the bourgeois elements in the Ministry of Health exalted the virtues of traditional medicine and condemned those who attempted to abolish it in the past (Crozier 1968). From 1953 to 1957 the Chinese government initiated a drive to reassess the medical heritage of China. Critically revised editions of ancient classical texts and a number of ancient collections, as well as modern textbooks encompassing essentials of theory and practice were printed. The first school for traditional Chinese medicine appeared in 1956 (State Administration of Traditional Chinese Medicine 1990).

During this period of revitalization of traditional Chinese medicine, the government undertook a widespread research project, screening hundreds of traditional Chinese herbal formulas and individual herbs. However, realizing that it would be too time consuming to conduct a comprehensive examination of the chemical properties of every herbal remedy, they focused only on the clinical effects and side effects. If the herbs passed these clinical standards, they became legal for use by TCM doctors and could be mass produced.

The importance of remembering the values of ancient Chinese traditions was again touted during the "Great Leap Forward" in 1958, but it was still under the auspices of Western science. Bibeau comments that,

> in fact, what parts of this cultural medicine were considered really valuable? Traditional remedies and a few technological devices... but surely not the anthropological foundations involving the original conceptions [of Chinese medicine]. (Bibeau 1985:940)

Chinese practitioners everywhere underwent retraining and the whole of traditional medicine was interpreted by most as a body of knowledge needing a qualitative 'leap forward'.

The main goal of the policy in the 1960's and 1970's was to protect, rather than to promote, TCM. True integration of medical systems, according to many sources, never materialized (e.g. Crozier 1968: Bibeau 1985). Bibeau (1985) believes that in 1960 and 1965 Western trained physicians were professional elitists and regarded the Chinese-trained doctors with condescension and contempt. He also believes that the failure to integrate Western and Eastern practitioners is a result of the structural impossibility of making a synthesis of two medical systems which have different bodies of conceptual pre-suppositions.

It was not until the early 80's that the development and promotion, rather than the preservation, of TCM began to be taken seriously. According to the State Administration Of Traditional Chinese Medicine (SATCM), developing the traditional medicine of the country was written into the Constitution in 1982. This new constitution declared that TCM should be put at the same level as Western medicine, and, furthermore, that TCM had special advantages that had to be

preserved and developed. However, traditional practitioners were supposed to use some modern methods to speed development of TCM. (SATCM 1990).

In 1985 the State council stressed that traditional Chinese medicine and Western medicine should have equally important positions, both legally and in terms of funding. In 1988, the government set up a new administration just for TCM, the "State Administration of Traditional Chinese Medicine" (SATCM). Traditional Chinese medicine now had its own administration whereas previously there was only a bureau in charge of TCM with all procedures falling under the umbrella of the Ministry of Health Care. Later that year, the new administration was expanded to include responsibility for all traditional Chinese herbs, which had previously been under an administration that dealt with drug use (Cai 1991). Table 1 presents a concise timeline of the above events. In 1991, there were 28 medical colleges of TCM in China. The same year, TCM was responsible for 40 per cent of the medical treatment of the whole country.

Present Status of Integrating Chinese and Western Medicine

In 1980, a new concept of "combination medicine" started to appear with more frequency in major policies. Traditional Chinese medicine had regained government acceptance and its effectiveness in filling the gaps of Western medicine was noted. A new party line endorsing the integration of TCM with Western medicine began to take root. In 1982 the first combination hospital was set up in Beijing. In 1991 there were 26 combination hospitals in China with a total of

Table 1:

Combining Traditional Chinese Medicine and Biomedicine; Chronological Development

Time Frame	Selected Policy Statements and Activities
1903	- Government accepts Western medicine and sets up the Medical Profession Academy.
1910 - 1911	- Great Manchurian Pneumonic Plague
1915	- Western medicine exclusively adopted for official medical curriculum.
1922	- Ministry of Interior defines two types of doctors. - Traditional doctors assigned to lower category.
1929	- Provisional Regulation for Physicians issued. - Traditional doctors excluded.
1930	- Provisional Regulation for Physicians re-issued under pressure from traditional doctors.
1930 - 1940's	- Traditional Chinese doctors unify and form professional organizations.
1949	- Founding of the People's Republic of China
1950 - 1951	- First National Conferences - Utilization of traditional doctors recommended for their access to rural population.
1950's	- Movements to revise critical editions of ancient medical texts & screen traditional herbal remedies.
1956	- First traditional Chinese Medical College founded.

Combining Traditional Chinese Medicine and Biomedicine; Chronological Development (continued)

Time Frame	Selected Policy Statements and Activities
1958	- The Great Leap Forward - Importance of ancient traditional Chinese values stressed.
1960 -1970's	- Traditional Chinese medicine protected, but subject to Western scientific criteria.
1982	- New Constitution. TCM at equal level with Western medicine.
1986	- First "Combination Hospital" set up in Beijing
1988	- State Administration of Traditional Chinese Medicine (SATCM) set up.
1990	- Country-wide questionnaire on health behaviour.
1991	- Debate persists on best way to train "combination doctors".

Source: Based on references cited in "Chapter Two" of thesis.

6,281 beds. Three of the combination hospitals are in Beijing. 95 per cent of all hospitals in China have a TCM department and there are more than 500,000 TCM doctors and 100 research institutes (Gao 1991a).

In 1990 the government issued over 10,000 questionnaires in nine provinces asking people whom they would see for their health care needs. They found that people would go to both Western and traditional doctors depending on their particular health need. Most peasants said that they would go to one doctor only, if they could get both types of medicine from that doctor. The present policy towards combination appears to be heading towards this ideal.

Medical insurance in China covers patients equally for either TCM treatments or Western medicine. The government provides different medical coverage depending on whether people are employed within state factories, are entrepreneurs or work for the government. In spite of this, generally everyone is covered for their needs. Lately the government has considered instituting user fees, particularly with TCM, as it appears that it is getting overused. Patients do pay a small fee for their own medications (TCM or Western). All provincial governments in China have the same basic policy for health care, although they are allowed to make adjustments to meet local conditions. Provinces with a large minority population may make policies that address minority medicine and practice, and further, allow for combination medicine between minority medical traditions, TCM and Western medicine. All provincial jurisdictions are controlled by the central Federal Policy.

China also has over 100 medical universities of modern medicine and 32 universities of TCM. Only three universities train combined doctors, a situation which Dr. Gao Yi-Min of the Beijing Health Bureau finds inadequate. The typical Chinese "combination-style doctor" comes from a background of modern medical training. After several years of practicing modern medicine, the doctors then train for two years in TCM and earn the title of "combination-style doctor", although they do not receive a diploma for these studies. Dr. Gao noted that the lack of a diploma is proving to be detrimental to encouraging more combination doctors. In most modern medical universities a half-year program of study is devoted to TCM. Likewise, TCM universities offer a half-year program of modern medicine. However, there is a double standard when doctors begin to practice medicine. Western medicine trained doctors are allowed to use TCM methods to treat patients in clinical practice simply because they have a degree from university, even if they did not receive any TCM training. However, TCM doctors can not use Western methods with the same freedom. Inconsistencies such as these have led to a widespread disagreement on the way to train combination doctors today in China. Some believe that a Western medical education is a necessity. Others believe that the education systems of Western and Eastern doctors must remain completely separate (Gao 1991c).

Western and traditional Chinese doctors are allowed to test new herbal preparations on their patients without prior approval from hospital administration.

In fact success in clinical practice is the first step in the approval of the effectiveness of a new herbal drug (Gao 1991b).

A Combination Hospital in Modern China

China's medical system is uniquely different from a biomedical system in that Chinese hospitals allow for a dualistic approach to health within one medical facility. Many physicians and patients, alike, stated that they had "the best of both worlds" by having access to both biomedicine and TCM. Dr. Wang Xing-Hong commented that if I was to fall ill, he hoped for my sake that it was in China. We have seen from the brief historical overview that traditional Chinese medicine has a long history. We have also seen how the increasing dominance of Western medicine stimulated a fight for the preservation of TCM. The history of the preservation of access to both TCM and biomedicine is complex and specific to China. TCM is not a pure tradition that has remained static. Rather, like any tradition, it has changed and evolved over time. However, traditional medicine in China today is in somewhat of a precarious position. On the one hand, officials promote the combination of modern medicine and traditional Chinese medicine, while on the other, the use of Western scientific methods are heralded as the best way to study Eastern medicine.

In the next section, I take a close look at two departments within a Beijing hospital to see how government policy concerning combination medicine translates in practice. In the traditional Chinese department, a parallel systems approach is

utilized, while the biomedical department is attempting a collaborative approach. The biomedical practitioners believe that they are achieving a full integration of medical systems. However, I will point out that this is not the case.

Research Methodology

The following information concerning the combination of TCM and Western medicine is based on field research by the author, conducted from June 21, 1991 to August 29, 1991, while living in Xuanwu hospital. Daily interviews were organized by the Beijing Health Bureau before arrival. A variety of administrators and hospital staff were selected by the Bureau for the project . Observations and informal interviews, utilizing open-ended interview questions, were conducted while visiting hospital departments, both within Xuanwu and two other hospitals. The project was approved by a University of Alberta ethics committee prior to funding. English and Mandarin speaking volunteers from the hospital provided translation during interviews. All interviewees were asked to give verbal consent before any data was collected. Data was either taped or recorded in notes.

Research is based primarily on the participant observation model, wherein the author,

> participates, overtly and covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he or she is concerned (Hammersley & Atkinson 1983:2).

The author lived in a room on the tenth floor of the hospital and was allowed access to most of the compound. On several occasions, visits were made to informants' homes to share in family dinners.

Research Objective

The original project objective was to explore the benefits of access to two medical systems within one country. I believed that the People's Republic of China had the best of both worlds by providing patients a combination of treatments from both medical systems. I had prepared questions along this line of reasoning. As I became increasingly immersed in fieldwork, I began to take interest in a more intriguing problem. I noticed that the two systems did not appear to be equal in status. I became interested in understanding why traditional Chinese practitioners and patients frequently apologized for their use of traditional Chinese medicine. I was interested in trying to understand which aspects of TCM were combined with biomedicine and why. This required a shift in focus and interview questioning. I began asking all interviewees what they thought of the medical system they were using. The results led to the formulation of the hypothesis that TCM is not accepted, nor utilized, as an entire medical system in combination. Upon returning to Canada, I undertook further research through literature to support my observations from China.

Such a shift in focus is not unusual in anthropological fieldwork. Using a "reflexive" approach in research allows the researcher to derive hypotheses and

test them out against further information gathered. Hammersley & Atkinson (1983) argue that this development of theory is particularly valuable because it prevents the researcher from formulating conclusions based on faulty preconceptions.

Xuanwu District Hospital

Xuanwu is a combination hospital situated in the southwest district of Beijing. It is in an older neighbourhood, consisting of many low-rise tenement buildings and traditional courtyard style housing. Xuanwu district is poorer than the communities to the north and west and includes a minority Moslem population living in the midst of the majority Han Chinese.

Xuanwu is a 530 bed general hospital established in 1958, with a staff of 1,612. It has 29 clinical departments which include both Western and traditional Chinese departments. On average the hospital serves about 3,500 out-patients a day. There are approximately 11,000 patients admitted each year and about 5,350 operations performed per annum. The Western wing consists of standard departments found in modern hospitals; for example, an emergency ward, surgery, neurology, obstetrics and gynecology, as well as 8 research divisions and 17 laboratories. The Chinese wing consists of a massage, acupuncture and traditional Chinese herbal medicine departments. In addition to these departments, there is a traditional Chinese herbal pharmacy and a TCM herbal processing plant on the

hospital grounds. Despite its size and variety of departments, Xuanwu maintains an operating budget of $450,000 (US dollars) per annum.

Observations were made in all traditional departments and a few Western departments. The attending physicians were observed at work, and informal interviews were conducted with patients who came in while I was there.

Observations and Case Studies in the Traditional Chinese Departments

The traditional Chinese herbal department of Xuanwu is located in a separate building across from the emergency ward in the main hospital. It operates on a drop-in basis, where patients wait their turn to see to one of three to five doctors on duty. Patients await their turn outside of the examination room. The examination room door is usually left open to the public, even during consultation with the doctor. Patients frequently bring family members into the examination room along with them. Once inside the examination room, the patient sits across a table from the doctor and undergoes traditional diagnosis that often includes a lengthy questioning period concerning the nature of the complaint. The patient is asked about any excessive emotional states he/she has experienced such as depression, sadness, happiness, anger, thoughtfulness, fear and shock. In Chinese tradition these are the seven emotional states that can cause illness. The doctor then examines the patient's pallor, notes any particular body odours, notes the colour and coating of the tongue and reads the pulse. In TCM pulse reading is an elaborate procedure. It is a particularly useful diagnostic tool involving

twenty-eight pulse signals, each one corresponding to a different organ system. Organs, as we know them in the West, and organ systems are not the same thing. Margaret Lock provides an example of this important difference:

> [In East Asian medicine] the idea of the lungs includes not only the lungs themselves but the entire respiratory tract, the nose, the skin, and the secretions associated with these organs. (Lock 1980:35)

TCM focuses on the function of an organ *system,* for example the lung system described above, whereas in biomedicine the focus is on the *individual* organ. Traditional Chinese doctors have to practice for many years to become skilled at detecting minute changes in pressure and pulse. There is no set way to read pulses. Young doctors apprentice with older doctors to learn their skills.

Dr. Zhou is a traditional Chinese doctor who studied for five years at the Capital Institute of Medicine in Pediatrics, and then worked at a Medical Staff College for two years in massage, acupuncture and herbal medicine. She works in the Xuanwu hospital drop-in clinic and specializes in children's common diseases. Dr. Zhou states that in TCM theory most children's diseases are caused by "evil - according to the environment" or, in other words, weather changes and unsuitable food (Zhou 1991).

The first patient in the clinic on July 2 was an eight year old boy with inflamed tonsils. When ill, his mother generally takes him to the TCM department in the hospital first. The boy's mother says that she believes in TCM because she was brought up by her grandmother who also believes in it. She says that TCM has no side effects and she feels that it is better for her son. The young boy's mother usually decides which department to visit depending on the kind of disease he has.

If he has a high fever she will use Western medicine to lower it and then give him herbal drugs. This particular morning she had gone to the Western department first and received a prescription for antibiotics and aspirin, but she had not planned to give her son the antibiotics unless fever became a problem. Dr. Zhou prescribed a blend of herbs and said that the boy's common cold could have been caused by excessive heat.

The next patient was a three year-old girl who had the mumps. Her mother is aware that Western medicine is unable to cure viral infections and that mumps are caused by a virus. Therefore, she brought her daughter directly to the TCM clinic. According to TCM theory, mumps are caused by excessive heat (Yang). Dr. Zhou believes that TCM can shorten the duration of the mumps. After she diagnosed the young patient, Dr. Zhou prescribed a herbal blend that can clear heat and toxic materials from the body and strengthen the Yin. The doctor explained that if there is a Yin deficiency, outside heat can enter the body and make the person ill.

Once given a prescription, patients are sent to the herbal pharmacy on the hospital site, to purchase their herbs. These can be purchased in traditional form (whole or chopped dried herbs that need to be boiled to make a tea) or in packaged and processed form (herbs that have been powdered or decocted and sold pre-measured). Dr. Zhou and many other TCM doctors prefer dispensing the traditional form although patients often find it inconvenient.

Dr. Zhou adjusts the herbal recipe to suit different physical and mental states of the patient, unlike Western medicine which is standardized into formal doses. Along with a herbal prescription, Dr. Zhou also advises patients of the appropriate foods to eat. Tonsillitis, for example, falls under the category of Yang diseases caused by excessive heat. Foods are all divided into Yin or Yang depending on their properties. Thus a patient with tonsillitis should avoid "hot" foods like pepper, and eat "cold" foods like watermelon, cucumber and bananas.

Dr. Zhou is involved in research on TCM when she is not on duty at the TCM clinic. Recent government policies promoting TCM are good, she says, although there is some confusion on the methods to provide combined training for doctors. She believes that this is a management problem, and that the government does not yet possess the necessary tools to carry out this goal. She thinks that the best TCM doctor comes from a TCM college background, taught by TCM professors. The TCM doctors who are trained in Western medicine are too weak in TCM theory and skills to make good doctors, she says, although she admits that having two kinds of skills is better.

There is an informal referral system between Eastern and Western departments in the hospital. Dr. Zhou, for example refers acute cases that require immediate attention to the Western wing. TCM is growing in popularity, rather than diminishing, according to Dr. Zhou. She claims that the medical climate around the world is changing to a greater belief in man as a part of nature. She

feels that the knowledge of TCM's value is increasing the number of people seeking it.

On July 4, in the TCM clinic I observed a woman in her early fifties. The patient was originally diagnosed in the Western wing as a severe diabetic. However, the patient did not believe in biomedicine and would not take insulin because she was afraid of side effects. She was using a special diet and TCM herbs to control her diabetes and found that it had been quite successful. She once tried stopping the TCM treatment and felt worse; so she has resumed taking the herbs. The TCM diagnosis for her is an energy deficiency and deficiency of the Yin. Dr. Sun Shu-ling, a TCM doctor, prescribed a special blend of herbs that is known to be especially good for older women with this condition.

The next patient was a younger woman who had a heart arrhythmia. As with the previous patient, she had been diagnosed with biomedical techniques, including an electrocardiogram. The biomedical doctor said that she did not have serious problems with her heart, and sent her to the TCM department because she still experienced pain. She came to the clinic because she felt ill. Dr. Sun read her pulse; it was "small" and weak. Her diagnosis was a lack of blood and vital energy. She said that soon after she took the herbs she felt better even though the herbs did not regulate the heartbeat. She prefers the TCM ward and thinks that Western medicine is absolutely useless.

A third patient, a young woman in her twenties complained of a fungal infection in her fingernails. She had also tried the Western department first and was

treated successfully for the fungal infection on her hands and face, but her fingernails were still infected. This was her third time in the TCM clinic. Dr. Sun observed her tongue. It was medium dark leading to a diagnosis of deficiency and stagnation of the blood. The patient had already taken 14 doses of herbal medicine and she felt better, but it had not cleared up the problem. Using her knowledge of three or four hundred herbs, Dr. Sun prescribed another herbal blend to treat her patient's symptoms, based on the same diagnosis but using slightly different drugs.

In the Acupuncture Department

The acupuncture department in Xuanwu hospital is located in the main building on the second floor. Patients await their turn in the hospital corridor on wooden benches. Once inside they are diagnosed with traditional techniques. They are then lead to a bed or chair, divided by a curtain from other patients, and given the appropriate treatment. The department of acupuncture uses traditional moxibustion and cupping techniques, as well as the standard acupuncture treatments which include electric current stimulation or laser-beam acupuncture needles for older patients. The department treats headaches, stomach problems, leg and shoulder nerve pain, joint pain associated with labor, facial paralysis and toothaches (Wang J. 1991). Acupuncturist Dr. Wang Jie-Li, studied at the Capital Institute of Medicine for five years. She has worked here for 14 years after spending 5 years in the herbal department.

Usually patients are first diagnosed by a Western doctor and then referred to this department. One very common referral is patients with ulcers in the mouth. Acupuncture treatments can prolong the period between getting ulcers, but not cure them completely. Other patients, who prefer TCM may come here directly to see the TCM doctor. Patients are reported to range in age from three to ninety years of age. Dr. Wang said that acupuncture is not just limited to the older generation which believes in it. It is re-gaining popularity these days because it is a non-toxic way to treat injuries and illness in the body. She said that on average the acupuncture department treats 50 patients a day (Wang J. 1991).

I spoke to one patient, a female in her mid-forties who was unable to close one of her eyes. She had first tried the Western department for a solution to her problem. They prescribed some hormones and vitamin B, but the results were not satisfactory, so she came here. She had been coming here for ten days and reported noticing an improvement. Dr. Wang stated that a patient, on average, usually only needs six acupuncture treatments before noticing an improvement.

Facial paralysis, which can be caused by a virus, is a very common ailment in China. Children with facial paralysis usually recover quite rapidly with acupuncture treatments. The treatment is not generally as successful with adults. I spoke to a middle-aged man with facial paralysis. He was in a late stage of the disease and while the prognosis was not good, he would still be treated with acupuncture. The doctor reasoned that perhaps she could help him feel better, even if acupuncture could not cure his paralysis. This line of reasoning is important in

traditional Chinese practice. Regardless of the prognosis a patient will not be turned away without receiving some care.

Although these case studies are not examples of a "combined" approach to medicine per se, they are good examples of the benefits of having access to two medical systems within one health care system. In the cases described above the biomedical system failed to provide the desired results. All patients then had the option of trying TCM. These observations of medical systems, in practice, demonstrate a parallel systems approach to medical pluralism. There are some superficial combinations of diagnostic techniques. For example, a few traditional doctors used a stethoscope during the diagnosis. Other traditional doctors considered the biomedical diagnoses when prescribing TCM herbs. Yet none of these examples illustrate a truly integrated system of combination medicine. The two medical systems remain distinctly separate.

Of particular interest, however, was the mutual referral system. Most traditional Chinese doctors had been exposed to some biomedical theory during their training and did not hesitate to send patients to biomedical departments. Biomedical practitioners also referred patients to the TCM department. Note the one case where the patient still felt ill, despite her biomedical doctor's reassurances. He sent her to the TCM ward. In TCM no one is sent home without a prescription because minute imbalances within the body are always detectable and treatable. By treating the patient with TCM in these cases, doctors confirm the patient's feeling that something is not quite right and provide a preventive cure for

a potentially difficult future illness. Biomedical practitioners are also generally aware of the benefits of TCM for prevention and sometimes will also refer patients who need psychological reassurance to TCM wards.

Observations and Case Studies in Western Departments

The neurology ward of Uamen Hospital in Beijing is the largest neurological department in China, with 120 beds and more than 30 out-patients a day. I spoke with Dr. Xie, Shu-Ping who works in the Cerebral Cystic Psychosis laboratory. She is graduate of the Beijing Medical college where she studied for five years. She now devotes most of her time to the study of cerebral cystic psychosis. This disease is a parasitic brain disorder which can manifest in a number of ways, for example, epileptic seizures, dementia, or meningitis. It is a common rural disease contracted by farmers eating improperly cooked pork. In the past this disease had a high mortality rate, but now, due to the use of both Western and Eastern medicine, prognoses are more optimistic.

Dr. Xie normally treats patients with a Western drug first, but she found that with some patients, the drug can be risky. If they have intercranial hypertension, they are given a TCM herbal medicine instead of the biomedical drug. Research on the treatment of this disease has shown that a combination of biomedicine and TCM treatments has the highest efficiency rate.

These biomedical doctors created their own blend of herbs for which they have received an award from the Beijing Scientific Society. Dr. Xie, employing her

knowledge of Western principles of diuretics, developed the blend of herbs with ingredients that had diuretic properties. The mixture of seven herbs was administered in tablet form. The tablets were tested for toxicity by conducting animal studies at the TCM research institute, then used to treat 1400 cases of cerebral cystic psychosis. Dr. Xie's team was preparing to publish their research results in a Western biomedical journal. Western and traditional Chinese medicine were both effective against the parasite, but the TCM herbal tablets had fewer side effects. Western medicine could kill the parasite quickly, but the parasite produced toxic substances as it died which excited the brain tissue to edema, thereby increasing inter cranial hypertension. The TCM pills killed the parasite slowly, dispelled the "wetness-evil" and acted as a diuretic. The medicine took longer to work but there was no intercranial hypertension (Xie 1991).

There are two common types of cerebral cystic psychosis. The first type includes intercranial hypertension and only TCM medicine is used to treat it. The second type has no hypertension and a combination of both TCM and Western drugs is used. The recovery rate for patients with intercranial hypertension was 94 per cent; the second type had a recovery rate of 100 per cent.

On July 18, I observed two patients who were treated with TCM for this disease. The first patient was a 53 year-old male. His presenting symptoms included a chronic headache over a 10 year period, epilepsy for one year, nodules under the skin and intercranial hypertension. His initial diagnosis was carried out with a CT scanner. When I saw him, he was in is his forty-fourth day in the

hospital. His hypertension had decreased and the nodules under his skin were gone. It normally takes months for a complete recovery. He was not given any Western medicine at all; only 4 to 6 grams of the herbal drug, two times a day were prescribed.

The next patient was a 33 year old male, from Hubei province. He was admitted to the hospital eight days earlier after complaining of intermittent headaches, convulsions and seizures. A CT scan revealed he was cerebral cystic psychosis positive. His treatment method consisted of two periods of different medications; one period, when intercranial hypertension was high, he took solely Chinese herbs, the other period, when the hypertension was lowered, he took a Western drug called "Droncit". The patient was recovering well and Dr. Xie expected that he would be released in a week.

Dr. Xie used her knowledge of Western diuretic principles and applied them to her knowledge of TCM herbs to form a new herbal drug. This is a combination of medical systems, but not true integration. Although Dr. Xie applied biomedical principles of diuretics to create a new herbal formula, the disease etiology (the parasitic disease explanation) is purely biomedical. Furthermore, a biomedical technique was the only method used in diagnosis. The treatment may have been a combination of both systems, but the pathology used to explain the results was biomedical.

Once again, this case study did not demonstrate a true integrative approach to health. In fact, this case provides an example of a situation now common in

Japan. Medicinal herbs are used but they are used outside of the traditional cultural context. In Japan, Kanpo clinics have readily adopted traditional techniques of treatment, such as dispensing herbal formulas. However, the traditional diagnostic techniques have all but disappeared, leaving a new Japanese tradition of lengthy waiting periods for brief and uninformative visits, with herbs dispensed as if they were biomedical drugs (Lock 1980).

In the case studies documented above, TCM herbs are also treated as biomedical drugs. However, Dr. Xie did not advocate synthesizing the herbs to make a stronger drug. Rather it was precisely the slow and gentle effect of balancing the system that she hoped to maintain. What we have then is a *selection* of a few traditional Chinese medical practices and herbs (therapy and materia medica) by biomedical practitioners, with little or no attention paid to traditional disease etiology, pathology or diagnostic techniques.

The next three case studies further demonstrate the benefits, and potential problems, of accessing both systems. I spent an extensive period of time with Dr. Wang Xing-Hong, from the gastro-intestinal department at Xuanwu hospital and was able to observe the entire treatment process of a few patients. Dr. Wang graduated from the Beijing Medical University in 1966, after devoting half a year to TCM. During his studies, he recalls one particular incident in which a classmate was cured of bronchial asthma by a TCM doctor. He was very impressed and decided to pursue TCM studies on his own after he graduated. He learned TCM systematically from books. In 1972, Xuanwu hospital established a group of

doctors who combined TCM with Western medicine to cure abdominal diseases. Dr. Wang was an active member of the group and reports that this is the style of medicine his ward still uses. He feels that Western medicine is more scientific than TCM so it should be the primary system used. However, to make up for its perceived deficiencies, he uses TCM.

On June 24, Dr. Wang introduced me to a female patient in her late fifties with an abdominal abscess. She had been admitted to the hospital a few days earlier and had an abdominal drainage tube attached. She also had a poultice of TCM herbs on her abdomen and had ingested a TCM herbal preparation for this condition. Her abscess was shrinking and it was determined that she would not require surgery. Dr. Wang pointed out that in the West the treatment would likely be to drain the abscess using surgery and a CT scan as a guide. In Xuanwu hospital surgery is seldom used for this condition as the TCM poultice and herbal preparation is so successful. In fact, a comparison study was conducted and the results indicated that TCM had the same effects as operating on abdominal abscesses. The doctors in Xuanwu prefer to use the TCM method because it is non-invasive (Wang X. 1991a).

The incidence of cancer is on rise in China and the Chinese are combating it with both medical systems. In the GI department of Xuanwu Hospital, they use CT scan technology in diagnosis and use biopsies to determine which kind of cancer it is. Subsequently, a patient has a traditional diagnosis by a TCM doctor including pulse reading, tongue diagnosis, facial pallor diagnosis and questioning. Thus each

patient is diagnosed by both systems. A lung cancer patient (biomedical diagnosis) for example, might be diagnosed, according to TCM, as having a weak lung and kidney. Biomedical treatment, would indicate surgical removal of the tumor, followed by chemotherapy and radiotherapy. This course of treatment is invasive and very hard on the patient. It has many side effects. At the same time the TCM doctor would give herbs to bolster the patient's immune system and make the patient stronger. The herbs help the whole body to recover. Chemotherapy suppresses white blood cell levels. Biomedical technology does not offer a medication to raise the white blood cell count, but TCM does. They can use herbs during chemotherapy to help maintain the white blood cell count at the normal levels. The herbs do not interfere with the effectiveness of the chemotherapy treatment. Additionally, the herbs stimulate appetite and treat generalized negative side effects to the digestive system. The biomedical approach treats only the carcinoma and is thus very specialized. The biomedical approach does not regulate the body's immune system as a whole (Gao 1991a). The doctors at Xuanwu think that the combination of methods can decrease the mortality rate and increase the recovery rate for cancer.

In the same department, a male patient in his sixties was diagnosed with gastro-intestinal carcinoma. After seven treatments with chemotherapy it was stopped and he was given a herbal formula to tonify the body. The seven chemotherapy treatments had dropped his white blood cell count. The tonic herbs helped boost his count. The treatment also restored his appetite and helped him

experience fewer side effects. The patient appeared healthy and vibrant and seemed to be recuperating.

Appendicitis patients are also commonly treated with a blend of both medical systems. I spoke to a fifty-six year old male with appendicitis on June 24. Three days prior, he had come to the hospital complaining of a stomach ache that started in the upper abdomen and had moved into the lower abdomen. He was admitted to the hospital and diagnosed with acute appendicitis. According to the principles of TCM, if a patient has had appendicitis for over three days an operation would be too dangerous and stressful. Instead, Dr. Wang prescribed a herbal formula that was designed to stimulate the intestine and clean out the abscess in the abdomen. To compensate for dehydration and nutrient loss due to the loose bowel movements (up to twenty times a day), the patient was given intravenous supplement to replenish fluids and nutrients. A TCM blend of four herbs was given in pill form. He took four to five pills, at a time, for two days. He was also given another traditional Chinese remedy in liquid form. The aim of the TCM treatment is to stimulate bowel movements to get rid of the toxic material in the intestine. The patient had severe diarrhea and experienced some pain, but it was determined that there was no need to remove the appendix.

I visited the patient ten days later and was surprised to find him mobile and recovering without surgery. He informed me that it took him only three days to feel better. He was due to be released after his residual abscess cleared. It was clearing slowly and so he was required to stay a few more days and continue

taking a secret and patented herbal formula. It was expected that he would be able to go home in two or three days. According to Dr. Wang, in these cases there is a 39 per cent chance of the disease recurring. If it recurs, an operation should be less risky because the inflammation should be confined to the area of the appendix. The first time it happens the inflammation tends to be diffuse (Wang X. 1991b).

The doctors in the gastro-intestinal ward consider two factors when deciding if a patient should receive an operation: whether the patient believes in operations, and whether the patient's symptoms have persisted for a long time. This patient had symptoms for three days and the appendix was surrounded by an abscess, a situation that is very difficult to operate on. At this point, Western physicians would not remove the abscess either. Rather they would make an incision and drain the infection first. Dr. Wang pointed out that in the West the patient would require a second operation. TCM therapy takes longer but it is non-invasive and therefore less traumatic. The average length of time for TCM treatment is one week, as opposed to two and half weeks recuperation time from surgery. Dr. Wang believes that the surgical process should be used only as a last resort and it is preferable to use the most conservative, non-invasive techniques possible. He believes that his knowledge of TCM gives him and his patients access to the best of both worlds (Wang X. 1991a).

Biomedical doctors do not use medicine for the purpose of stimulating diarrhea. Yet, in traditional Chinese theory diarrhea is often necessary to cure patients. Biomedical practitioners and traditional Chinese practitioners differ

greatly on this point. The formula that Dr. Wang uses is an updated version of a traditional formula. The main ingredient is a purgative herb that stimulates the mucous membrane of the stomach to secrete fluid and cause diarrhea, while at the same time promoting the constriction of the intestinal muscle. The other herbs reduce the toxicity of the main ingredient, so they have to be used together (Wang X.1991c).

Dr. Wang believes that access to both medical systems provides patients in his ward an integrated medical system. However, it is only in this case of appendicitis, that traditional Chinese principles are seriously considered. Biomedical theory and TCM theory each dictate a different course of action: surgery versus bowel movements. In this case it is TCM that is borrowing a treatment method from biomedicine: intravenous nourishment and fluid replacement. Theories from both systems are not integrated. In the other two examples, treatment methods were combined, but only when TCM was able to provide a (herbal) drug where biomedicine could not.

Integration of TCM and Biomedicine in a Chinese Hospital?

The history of the co-existence of two medical systems in China is more a product of a changing political climate rather than a recognition of the value of a combined approach to medicine. Traditional Chinese medicine exists today because it is closely linked to Chinese culture and the rural population depends on it for primary health care, but most importantly because the present government endorses it. Western science is popularly perceived as being modern and, it seems

that, China desperately wants to be accepted as a modern nation by the global community. Therefore, biomedicine quickly gained popularity and biomedical doctors are reluctant to loosen their grip.

Medicine is not immune to political forces. Indeed, we have seen how, in China, the shifting of emphasis on biomedicine and TCM have been strongly influenced by politics. Currently, in the quest for modernization, Chinese health practitioners, both biomedical and traditional, are applying biomedical standards. During the course of my research, traditional Chinese doctors often appeared apologetic for their complex traditional theoretical explanations, and many practitioners aspire to be more scientific in their methods.

It appears, that in China today a "combined" approach to medicine is coming to mean that only TCM practices that make sense in Western terms are endorsed. The combination of the two medical systems is attempted in the biomedical department, but only in diagnosis, therapy and materia medica. In daily practice, the medical system of China demonstrates either a parallel systems or a collaborative approach to health care, which may involve mutual referrals or the combination of diagnostic and therapeutic techniques, but not true integration. Although official policy in China aims for integration, true integration is not manifest in practice. To have true integration, disease etiology and pathology would have to combine both Western and Eastern theories to create a new integrated theory. To date, it appears that these two areas are precisely where such attempts fail. While it is beneficial to access different diagnostic techniques and

treatments, it does not increase our understanding of the illness process as a whole. The next chapter examines some of the reasons for this situation and implications for integration worldwide.

Chapter Three

Specific Issues in Combining TCM with Biomedicine

In the first chapter, an examination was made of the reasons for the integration of traditional and modern medical systems. In the second chapter we looked at the specifics of the Chinese medical system and saw that the integration of TCM and biomedicine was successful at some levels (e.g., combining certain therapeutic approaches and diagnostic techniques) and unsuccessful at another level (theoretical conceptualizations). In this chapter, obstacles to present integration attempts, using research from China to provide examples, will be examined. Secondly, I attempt to shed some light on why such obstacles to integration may be occurring. I approach a discussion of these obstacles in the following order: theoretical differences, political hurdles, and repercussions of their interaction. Finally I make some suggestions pertaining to policy approaches to the interaction of biomedical and traditional medical systems.

What Exactly Does Illness Mean?

Kunstadter notes that "illness generally seems to imply interference with normal functions" and that "universally applicable definitions of illness have yet to be worked out" (1974). Many social scientists have been studying the interaction of culture, health and illness (e.g., Kleinman 1974, Leslie 1980, Bibeau 1985, Young 1983). However, exact generally accepted parameters for what constitutes illness have not been established.

Culture is identified as the strongest force in the recognition and identification of what constitutes an illness. Kleinman claims that illness is in large part a cultural construct while "disease occurs as a biological and psychological phenomenon that may or may not have cultural determinants" (1974:600). Although Kunstadter does not differentiate between disease and illness, he believes that some illnesses have a biological component that is universal (e.g., the relationship of smallpox virus to smallpox disease). According to Kleinman, the sick role, illness behaviour, and experience of illness are all socially constructed (1974). Moreover, he believes that culture has the greatest impact by giving meaning to the illness experience. Medical anthropologists, like Kunstadter and Kleinman, who study the interaction of culture and illness conclude that they are intrinsically entwined. For every illness there are a variety of symptoms and behaviours, all of which are culturally dependent.

In Chapter One, a medical system was defined as a system composed of five important elements: etiology, pathology, diagnosis, therapy, and materia medica. The etiology and pathology together construct the theoretical underpinnings of a medical system. That is, they provide the context for the other three aspects. For example in TCM, concepts of yin and yang and the five elements in dynamic equilibrium provide some of the etiologic concepts; while balance, environmental conditions and excessive emotional conditions provide some of the concepts of disease pathology. Diagnosis, therapy and the materia medica are manifestations of the conceptual framework or context. For example, in TCM

diagnosis, procedures such as pulse, pallor and tongue examinations determine where there is an excess of yin or yang within the body, which of the bodily systems are out of balance and what environmental or emotional condition preceded that condition. Therapy consists of balancing the system using a number of therapeutic tools, for example, acupuncture or herbs.

Thus, etiology and pathology can be said to make up the cultural context of a medical system, by providing the theoretical framework for the actions and tools of that medical system. The theoretical framework provides the focus and is at the base of every practical application of a medical system. This framework provides a system for selecting and organizing the natural world while at the same time remaining in a feedback loop with the practical applications.

These five factors are all cultural constructions yet they function on two distinct levels; theory and practice. For example, in practice, combining treatments may indeed increase the repertoire of treatment techniques, but it does not enhance a global understanding of theoretical issues, such as disease etiology. Extracting only the practical aspects of a medical system is akin to extracting only the active ingredient from a plant. While the active ingredient may be of use, the entire plant has a level of complexity that imbues it with new properties. Vuori notes that,

> after decades of analytical research aimed at extracting specific active substances, it might be a good idea to place the accent on utilizing the entire plant... In application to medicinal plants, whose compositions is invariably complex, this theory confirms the traditional theories, according to which a plant in its entirety has properties which form those of its constituent parts. (1982:136)

Likewise, examining only one or two of the five factors that comprise a medical system can distort our knowledge of the whole medical system (Kleinman 1978).

Combining complete medical systems is far more complex than it seems. For instance, terms such as "combination" and "integration" are often used interchangeably, but they do not carry the same meaning when applied to medicine. Integration is defined as "the act or an instance of combining into an integral whole" (Webster's Dictionary 1989:738). Applied to medical systems it implies a complete synthesis of two, creating a new and unique third system.

Unschuld agrees that the distinction between theory and practice is neglected in China. He believes that Western scientists do not seriously consider traditional Chinese theory,

> In addition to this one-sidedly integrative trend of co-existence, there is a second, which can be termed cooperative, meaning that a therapeutic procedure combines Western and traditional techniques or drugs, without any common theoretical basis. (1985:262)

Unschuld strongly criticizes Western attempts to integrate TCM into biomedicine.

In WHO guidelines, the materia medica (the traditional practitioners and the drugs used by them) receive by far the most attention. Vuori notes that,

> The etiological and pathological theories of traditional medicine are often brushed aside as unscientific, and they are usually not the central focus of WHO's interest. (1982:135)

Furthermore, in WHO literature, the Chinese medical system is repeatedly noted as an example of successful synthesis of two systems and the model to follow (e.g., Vuori 1982; Akerele 1984). However, as demonstrated in chapter two, not one case study approached a theoretical integration of biomedicine and TCM. All cases

focused more on one of the two theories, but borrowed treatment methods from the other.

Biomedical Systems and Theoretical and Political Structure

There are a number of factors which may limit a biomedical practitioner's understanding of traditional Chinese medical theory. Firstly, medical systems, in their entirety, have their own theoretical conceptions. Biomedicine and TCM have different theoretical starting points and these starting points guide, what Patel labels, their "world views" (1987). Patel believes that many non-Western medical systems are not accepted because of a difference of world views. These world views are manifested in many ways and ultimately can be discovered in discussions of the different models. He notes,

> Scientific medicine [SM] is based on the biochemical aetiological model; alternative medicine liberally uses terms such as `energy', `holism' and `harmony'. While nominally equivalent concepts exist in SM (physical energy, interaction, equilibrium), quite different usage is made of them. (1987:669)

Patel argues that although translating the language is a useful exercise, it is not enough to know the language of two medical systems while usage is different. For instance, in biomedicine empirical data are communicated through conventional standards of measurement (Porkert 1974). These standards are mathematically stated (e.g., combustion at 380 degrees versus the statement "a hot fire"), and provide a precise and intelligible exchange of information within a community. Of importance to note is that the conventional standards do not impose or represent any natural law in themselves. They are simply standards for communication that

require highly technical and sophisticated equipment for measurement of observable phenomena. Therefore these types of standards fit very well with an industrialized and technologically oriented society. Applying contemporary terminology, these standards are called "quantitative measures". Porkert further states that,

> by contrast, Chinese science, e.g. Chinese medicine at all times has employed the inductive and synthetic approach, directly yielding statements on functions. If we attempt to define similar functions with reference to space, the criterium is not their quite illusive respective dimensions but, instead their relative direction (1974:63).

Porkert appropriately labels this a "qualitative" statement. Communication in Chinese medicine, unlike in biomedicine, relies upon standards of value, or qualitative standards, such as balancing Yin and Yang and the Five Evolutive Phases (Wu-Hsing). For anyone to penetrate into the scientific systems of Chinese medicine they must have a knowledge of these standards of quality because,

> the attempt to judge Chinese medical theory by the utterly alien procedural standards of Western medicine is not the only way in which its highly consistent data are obscured (1974:63)

Porkert argues that the positive truths of Chinese medicine remain valid despite the passage of time, and that the theoretical mainstays of TCM "represent an unusually pure rational system" (1974:64). Western and Eastern science simply apply logical premises differently. However, the validity of the Chinese approach is rarely acknowledged, notes Porkert:

> a few scientists of all disciplines today still persevere unchallenged in the opinion that it is exclusively the causal and analytical mode of cognizance that leads to the positive perception of reality. (1974:72)

Moreover, traditional Chinese medical theory includes elements not commonly associated with biomedical definitions of health. In China, for instance, natural elements of wind and cold are environmental constructs and are included in the etiology of illness. In biomedical etiology, environmental factors are not included in the general theory, although some individual practitioners may consider them. However, when biomedical theory and practices are adopted outside of Western countries, a biochemical definition of health is automatically accepted along with it. Alternative viewpoints to disease causation are no longer considered useful. Geiger notes that,

> the definition of health care services as a 'rational scientific activity' rather than a social activity tends to serve the interests of its constructors and practitioners, rather than the interests of the consumers. Yet consideration of any organized effort to change this brings us, at the close, to the central barrier to adaptation of Chinese health-care approaches in our own society: the enormous difference in the social ethic, there and here. (1974:723).

Biomedical explanations of disease are uniquely suited to a society where its members are highly individualistic.

Koch-Weser believes that within the biomedical system, a political statement is made by ignoring relationships to illness outside of the areas for which the government is responsible. The biomedical definition is only one approach to many health and well-being issues but imposing biomedical standards tends to invalidate other systems of medicine not based on this model (1974).

The second factor that limits an understanding of traditional Chinese medical theory is support from the official sector. Ideological differences are often expressed by the support of only certain practices by the government. For

example, the research and development level of medicine in China encourages research on acupuncture and herbal therapy. Bibeau claims that these are elements of TCM that resemble biomedicine the closest and they are arbitrarily extracted. He says that a few technical aspects are validated, "with a more or less global refusal of the theoretical foundations of the entire system" (1985:940). The same selection of appropriate elements is happening in Nepal and Mali. As Adelman notes,

> the official sector determines which practices are suitable for integration and which should continue to exist without official recognition. Therefore those elements that resemble science are identified and are moulded into the scientific paradigm. (1992:52)

Official support of certain practices can promote the view that a traditional medical system is less scientific, and hence, less modern, than biomedicine. Lee offers an explanation for this based on his study of traditional practitioners in Hong Kong. He concludes that biomedical science is highly valued and beliefs about its superiority have seeped into health care,

> as a result, anything which is developed in advanced Western nations and is connected with science will be accepted with little resistance... Second, because of cultural consciousness, the government is more sympathetic to the use of Western ideas and technology than to indigenous practice. (1974:231)

One reason for this may be due to belief in the superiority of expertise from the West, and the quest of the Chinese government to modernize in order to compete in a global economy. Unschuld notes that the recent desire to modernize in China is not new. Modernization was also highly desirable in the beginning of the twentieth century,

> ...how can one explain the unparalleled attraction and persuasive force that the concept of modern science, which was so foreign to the Chinese, exerted on reformers of all possible political beliefs at the beginning of this century, such that for a period of time the term *science* was synonymous with "modern civilization". Certainly the desires of many to adopt Western values and even the entire Western culture, in order to restore to China the international greatness that had marked its foreign relations during past periods of glory, was just as decisive as the model of Japan, which in short time had been able to assimilate significant elements of Western civilization. (1985:243, emphasis in original)

Efforts to modernize and assimilate elements of Western culture are not unique to China; they are taking place all over the world. As Lee notes, "these efforts are likely to lead to absorption of alternative remedies into scientific biomedicine" (1982:639). Obeyesekere compared modernization of Ayurveda in India and TCM in China in a response to an article by Leslie. He observed a generalized modernization trend in China and said,

> I hesitate to call the emulation of the Western model by Ayurveda a modernizing process. Here perhaps lies the difference between the Chinese and Indian examples. Both perform crucial functions in contemporary life but the Chinese is based on a deliberate modernizing strategy.... Also the Chinese case is part of a larger planned strategy of modernization whereas the Indian case is not. (1975:420)

Lee points out that a medical system can achieve dominance through official support allowing it to become structurally superior (1982). Structural superiority includes governmental and institutional support for a medical system, addressing issues such as who controls health affairs, which system receives respect in the community, who receives the economic resources and who has the most power, prestige and wealth. From his study of Chinese health policy, Lee

concludes that although policies favour the equal standing of TCM and modern medicine, and some attention is focused on acupuncture and herbal medicines,

> in terms of power over health affairs, the profession of Western science is still superior to the profession of Chinese medicine. The Ministry of Health ...is dominated by Western-style doctors... Even at the level of rural communities, Western-style doctors are more powerful than their Chinese-style counterparts (Lee 1982:633)

I submit that the same is true in Beijing. People from a variety of backgrounds appear to have accepted the belief that biomedical science is superior to Eastern methods. This became evident in a number of interviews conducted by the author and some of the following examples will help demonstrate this fact.

Dr. Gao Yi-Min, from the Beijing Health Bureau believes that combined training in both medical systems is best. He remarked that there are 5,312 modern doctors who have learned TCM and are at the professorial level. A majority of these doctors are heading the teaching and research on combination medicine. However, the amount of TCM theory these modern doctors receive in medical school is minimal. TCM theory and practice is usually covered by one single course in medical school (Gao 1991a).

On other occasions I recorded contradictory statements during interviews with health professionals. On the one hand, many strongly advocate research on traditional Chinese medicine using Western methods, but frequently and often in the same interview, Western research methods are deemed inappropriate for TCM. Dr. Gao, during the interview noted above, stated that it was not possible to use modern pharmacological methods to do research on herbs. He said that herbal prescriptions have combined effects on the body which are difficult to isolate under

the Western microscope. He also said that there are elements of TCM that cannot be explained with modern science. Gao concluded that he believes TCM is not something that Western science can be applied to at present (Gao 1991a).

Other contradictory statements were recorded in an interview with Dr. Tian Bao, attending surgeon from the gastro-intestinal department. Dr. Tian frequently prescribes blends of herbs, but does not use any TCM diagnostic techniques. In fact he has no TCM training whatsoever. When asked about his knowledge of TCM theory he said that he learned how to use some TCM herbs in his modern medical college. He is legally allowed to use whatever medical system he prefers, in spite of his lack of TCM training (Tian 1991). Dr. Tian's application of TCM is a good example of the dichotomy between theory and practice. Health care policy that allows Western practitioners to use both systems, yet disallows the reverse, exemplifies Lee's conclusion that biomedicine is structurally superior in China.

Dr. Wang, also from the gastro-intestinal department, stated that traditional Chinese theory is not very scientific. He recommended using Western scientific methods to research TCM in colleges. However, later during the same conversation he cautions that it is really difficult to apply Western medical theory to TCM, but that is their objective. Yet when asked about the best way to learn how TCM works, Dr. Wang replied that TCM theory comes from practice and there are no better research methods to understand the relationship of body and emotions (1991c). Thus, in some instances Wang endorses subjecting TCM to

biomedical research, while in others (studying emotional states and their impact on the body), he supports traditional clinical research techniques only.

During a few interviews with TCM practitioners I noted that there are a variety of contexts within which the term "science" was used. In an interview with Dr. Zhang Shu-Qin, the director of the traditional Chinese pharmacy at Xuanwu Hospital, she expressed a desire to run the pharmacy more scientifically. When pressed on what she meant by scientific she said she wanted to manage the pharmacy by computer. Using a computer would allow her to use modern management techniques and the most recent technology. However, it is unclear how, simply by using a computer, she would achieve "scientific management". Science in this context appears to be synonymous with modern and "like the West" (Zhang 1991).

In brief, theoretical differences and political factors (such as structural superiority and the pull to modernize) affect any serious consideration of traditional Chinese medical theory in the integration process, by biomedically trained personnel. In the next section, we take a look at the interaction of the above factors.

Baer specializes in the analysis of health care systems and how they fit into the political and economic system of the country in which they exist. In his study of the American system and its treatment of alternatives he states that biomedicine neglects the social roots of illness, choosing instead to focus on individual responsibility for workers to restore themselves to a level of functional health. This

is uniquely fitted to a capitalist market economy and allows the social problems which may be factors in the causes of illness to be ignored. Research and legitimation favour an individual biological model of health and that model is reinforced by

> patterns of legitimation and even professionalization of various alternatives... (that) reflect the growing accommodation by alternative practitioners to a reductionist disease theory which is compatible with capitalist ideology, and to the biomedical model of organization. (1989: 1110)

Baer concludes that the capitalist system forces alternative medical modalities to adjust in order to become popular,

> Given these tendencies, biomedicine may easily be able to co-opt the techniques of specific heterodox medical systems, such as acupuncture, while discarding their theoretical or metaphysical premises. (1989:1110)

The same co-opting is taking place in China. From the survey of practices and discussions with officials, alternative and metaphysical explanations that do not conform to a bio-chemical interpretation of disease etiology are not well supported. The official sector is dominated by professionals trained in biomedicine with a limited exposure to TCM. Lampton states that, "one should note that medical researchers and professionals had a pervasive influence on science policy-making, even during the Leap" (1977:106).

Wolffers remarks that, in general, when traditional healers are discussed by the WHO, plans for their integration appear in a form of "vertical management", because decisions are made on what is harmful for a community, without first consulting the members of the community (1990:5). Bibeau concurs and states

that this type of approach sees traditional practitioners useful only in a stop-gap approach and assumes that biomedicine's superiority is self-evident (1985).

Other medical anthropologists studying the interaction of politics and medicine believe that within a biomedical discourse, the political roots of medicine are seldom critically examined (e.g., Baer 1989; Singer 1990). More importantly Western medicine is perceived to exist without any cultural baggage.

Singer aims to dispel this myth by pointing out the cultural context of biomedicine. He claims that biomedical roles are a microcosm of class, sex and race distinction in a capitalist society. He notes that in the study of Western and non-Western medical beliefs, non-Western medicine is treated as an example of culture, while "Western medicine is an example of SCIENCE" (1990:181, emphasis in original). The distinction is evidenced in the assignment of the term "culture-bound syndrome" to diseases outside the realm of Western identification.

Singer is not the only critic. Others argue that biomedicine needs deeper self-examination. Nichter says that when biomedical scientists claim not to be motivated by anything other than scientific goals, they are making an ethical comment (1991). Geiger claims that we have "a non-rational faith in the efficacy of scientific technology and pharmacology" and it is "a popular belief which is shared by the practitioners of the system" (1974:716). Farquhar argues that even by delineating theory from concepts, Western trained researchers are imposing categories and conceptual distinctions that do not reflect the realities of different peoples,

> Our ability to speak of the 'epistemology' of a 'medical system' depends upon our point of view as observers informed by a discourse distinct from that under study, a discourse in which certain knowledge on the geometrical model has been an issue at least since the enlightenment. (1987:1013)

In her recent book, Farquhar (1994) goes on to argue that scientific evaluation of Chinese medical knowledge can only fragment the historical and practical reality of it. She believes that the practice and experience of Chinese medicine are inextricably entwined, creating an entirely different experience of knowledge that does not lend itself to evaluation by biomedical standards.

Issues such as these need to be understood in order to allow a sharing of knowledge between systems. As it stands in China today, traditional Chinese practitioners are not treated on par. According to Leslie,

> The regular health professions are the major source of resistance to the rational utilization of "alternative therapies" for planning in both industrial and developing countries. (1980:194)

Kleinman states that "doctors have a trained incapacity to regard anything outside their own system as useful" (1980:56). Furthermore, he believes that the professional socialization of health workers, through educational and social institutions, causes them to view their notions as rational while others outside their field are irrational and unscientific (1980). Unschuld strongly argues that Western researchers must have a thorough understanding of the history and present context of biomedical traditions before beginning to understand, let alone evaluate, other medical traditions,

> Researchers - no matter whether they approach Chinese medicine from the perspective of medical anthropology, sociology, history, or philosophy - should be aware of the risks emerging from a situation where authors, after spending considerable time and many efforts to getting access to Chinese medicine, are unable to match their knowledge on Chinese medicine by a similar degree of knowledge on the conceptual development and background of traditional European and modern Western medicine. (1987:1028-9)

To sum up, traditional Chinese theory provides an alternative to biomedical theory in China. However, due to a lack of understanding of theoretical and socio-political factors, integration of the complete system is unlikely, improbable and, in the end, undesirable.

Another Look at Policy Initiatives

The Chinese medical system is not an integrated health care system. Some want a full integration and believe that having one dominant system is a strength. Others say that because it has not moved to full integration, it allows for variety and personal choice.

In the first chapter I outlined the four types of systems discussed in a WHO article and used them as a basis for categorizing policies toward health care systems. What should now be obvious is that these policy categories are far too simplistic to guide policy initiatives.

Young (1994) has defined models of health care pluralism, and I believe that these are of more use. Countries characterized by health care pluralism are divided into two types. The first type encompasses parallel independent traditions and has the following characteristics:

1) two or more health care traditions are legally recognized
2) systems operate independently, with little cooperation between systems
3) patients utilize both systems according to needs.

The second type involves active collaboration between legally recognized traditions and has these characteristics:

1) two or more systems are legally recognized
2) systems operate independently, but with mutual referrals and collaboration in the diagnosis and treatment of patients.
3) patients utilize both according to needs.

Young goes on to argue that genuine integration of health care traditions would eliminate pluralism and reinstate a single orthodoxy. He believes that genuine integration, even if possible, is not desirable. Despite attempts at integration, the Chinese system today resembles an "active collaboration" type of health care pluralism more than an integrated system.

To provide culturally-appropriate care, a complete integration of medical systems should not be advocated. As long as the cultures of the world remain diverse, so too will their medical systems. Viewed in this light, medical pluralism, in the form of the active collaboration, is the only satisfactory way to address human illness. Kleinman states that,

> Medical systems are virtually impossible to understand once they are removed from their cultural contexts. The cultural context does not merely tell us about the social and cultural environment within which a particular local system of medicine is situated, but also tells about the specific cognitive, behavioural, and institutional structure of that system, and the cultural constructional principles (values and symbolic meanings) underlying and determining that structure. (Kleinman 1974:597)

I believe that having a number of medical systems within one country, in active collaboration, allows for a broad spectrum of solutions to medical problems.

This is the system that also allows for culturally-appropriate treatment. The WHO is promoting integration as a means of providing culturally appropriate care. However, at present, the WHO's conception of integration, by failing to recognize the theoretical concepts of traditional medicine, weakens traditional medicine and hence does not make true integration possible. The effect of this is that culturally appropriate care is not achieved; in fact the opposite is often the result. Complete integration, at present, remains impossible because of political, social and conceptual hurdles. Active collaboration, at this time, remains a more plausible and desirable approach.

Furthermore, traditional medicine and biomedicine have different strengths. It has been demonstrated that traditional approaches are most efficacious with chronic, stress-related diseases (e.g., Lock 1980). Biomedicine is most efficacious in crisis situations requiring aggressive intervention. Traditional medical systems and biomedicine can thus be viewed as being efficacious in different areas. They should not be viewed as competitors but as opposite ends of a healing continuum. This situation calls for active collaboration rather than integration. As demonstrated, integration tends to emphasize one end of the continuum at the expense of the other. To encourage exchange and sharing, however, medical systems need to be considered in their complete context.

In light of attempts at integration in China and the weaknesses discussed, I believe that it could be advantageous for policy initiatives regarding traditional and biomedical systems in countries that have a well established and popular alternative

to biomedicine, to follow an "active collaboration" approach. Although the reader may argue that cross-referrals and informal cross-system exchanges will ultimately lead to a third theory of medicine and a single orthodoxy, I think it is unlikely as long as the concept of the medical continuum is preserved. While new and beneficial treatments for disease might arise from active collaboration, the cultural and individual diversity of humans will help to preserve a diversity of healing traditions. In the meantime however, pursuing an "active collaboration" model of health care pluralism would ensure that traditions such as TCM would survive because they would remain separate from biomedicine and hence leave such future possibilities open for exploration.

Conclusion

All of the countries in the world today experimenting with integrating biomedicine and traditional medicine are not truly integrating complete medical systems. Traditional diagnosis, therapy and materia medica (determined to be useful according to biomedical standards) are incorporated into biomedical practice, while theoretical concepts are ignored. In the People's Republic of China, this incorporation is official policy and results in what is known as "combination" medicine. The WHO, using China as a model, advocates that countries combine biomedicine and traditional medicine through integration. However, to provide culturally appropriate care, to protect the theoretical mainstays of traditional

medicine and to help maintain a diversity of solutions to human medical problems, two things must be done.

First, I believe that an active collaboration model (rather than an integrated model) should be endorsed. Active collaboration allows and maintains a diversity of belief systems, which in turn provides culturally appropriate care. It allows for cross-system exchanges without trying to assimilate the other medical system. And finally, it does not necessarily lead to one dominant orthodoxy.

Second, further research is needed to promote a broader understanding of the socio-political factors of *all* medical systems (biomedicine included). One dominant medical system is insufficient to meet all needs. We have to re-examine the methods advocated to solve this problem. This is a timely issue. Just as potentially medicinal plants are destroyed in the pursuit of certain resources, if biomedical theory dominates and subsumes all other medical theories, a body of potentially beneficial health knowledge will also be lost.

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